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ABSTRACT

Of grave concern to all who are involved in the delivery of health and mental health services are two recently-observed trends in the drug and alcohol abusing population: the emergence of formerly hidden individuals in need of treatment (among them women, children and the elderly), and the increasing incidence and severity of emotional problems among abusers. How much these changes are a reflection of a general raising of consciousness or an indication that society is becoming "sicker" is a moot question. The issue of concern is whether the existing human service systems are equipped to handle these growing problems, whether newer modes of organizing health services are addressing these needs; in short, whether society is prepared to make a full commitment to all population--segments including those who are drug dependent and drug abusing. To do so, means to address a number of factors that are relevant to health care generally and are essential if the health problem is directly or symptomatically that of alcohol abuse. (Author)

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# THE DELIVERY OF ALCOHOLISM SERVICES:

# MEETING WHOSE NEEDS?

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## I. INTRODUCTION

Of grave concern to all of us who are involved in the delivery of health and mental health services are two recently-observed trends in the drug and alcohol abusing population: the emergence of formerly hidden individual in need of treatment (among them women, children and the elderly), and the increasing incidence and severity of emotional problems among abusers. How much these changes are a reflection of a general raising of consciousness or an indication that we are moving in the direction of a "sicker" society, is a moot question. The issue with which we must concern ourselves today is whether the existing human service systems are equipped to handle these growing problems, whether our newer modes of organizing health services are addressing these needs; in short, whether we are really prepared to make such a commitment to all segments of society - including its drug dependent and drug abusing population. To do so, means to address a number of factors that are relevant to health care generally and are essential if the health problem is directly or symptomatically that of alcohol abuse.

Too often, such factors as age, marital status, ethnicity, sex, education and occupation, are merely entries on an intake folder. Yet, planned application of knowledge of the complexity of these factors, along with knowledge of family structure, social class, life styles and strivings, could contribute to understanding the course of illness and to designing appropriate services. When these socio-cultural factors are overlooked, it is regrettable; when identifiable groups must suffer from the illness, yet remain unserved, it is unnecessary and tragic.

To the degree that organized health care settings address these factors, they will be more likely to prove effective.

## II. THE EMERGENCE OF THE HIDDEN ABUSER AND THE POTENTIAL VICTIM

### A. Women

Today more and more women are beginning to reveal what their families have blinded themselves to for years -- their dependency upon alcohol. As women become freer to drink in public, the visibility of female alcohol abusers becomes greater. Yet, despite increasing human evidence of what has become an increasing public health problem, the mounting hard and soft drug addiction and the greater visibility of female drug abuse and alcoholism have not been matched by an increase in attention to these problems or their effects. Public policy assigns limited resources to their solution. Denial is an easy mechanism to cope with the disquiet women addicts and alcoholics provoke.

A cursory look at the facts and figures relating to women, alcohol and drugs might suggest that there is a direct relationship between the rise in female abusers and the rise in mental illness, since earlier literature produced evidence that women who use drugs are "more disturbed" than men. However, a closer look at the reasons women drink or pop pills, the differential treatment they receive, and the criteria used to evaluate the problem leads us to different conclusions.

What is the social context in which women live today in this country? Alienation and role confusion in our rapidly changing society create uncertainty for them. Their aspirations increase, but opportunities remain constricted. If they are victims of addictive diseases, their lowly position is intensified by the devalued status assigned to all who are disabled by addiction and drug dependency, from the addict in the alley to the recovered alcoholic. The interacting forces affecting them illustrate some of the critical issues around sexism in the fields of alcohol and drug abuse services. They must be resolved if we are to adequately address changing needs.

Although many women will deny that they have been affected by Women's Liberation, the connection between the patterns of drug use and the social changes wrought by shifting attitudes towards women indicates otherwise.

Whereas society's mores might have inhibited women drinkers before, young women are increasingly experiencing problems with alcohol as early in life as men. In a recent survey of New York City's public high school students, it was found that 54 percent of the seventh grade girls had tried alcohol although not as often, compared to 63 percent of the boys, and that this figure rose to 87 percent by grade 12. Unfortunately, this experience is not matched by knowledge about the effects and dangers of drinking and drug abuse. The family practitioner listens to the woman who masks her inner conflicts with physical compliants or handles her anzieties with alcohol. Tranquillizers are prescribed and cries for help are overlooked until the problem becomes dependency and dependency becomes abuse.

Furthermore, as women are exposed to greater stress and competition, they are more likely to use alcohol or pills or both to control anxiety. Evidence of increasing numbers of single and divorced women indicates that the proportion of households headed by women is higher today than ever before. Yet the average income of working women over 40 is $6,000 per year, half that of men the same age. The hardship of economic pressures, the personal crises of separation, divorce or desertion can frequently lead to the alleviation of stress and strain through the use of alcohol. Not surprisingly, women who habitually use mild tranquilizers such as Valium are achieving the same effects.

Recent disclosures by the National Council on Drug Abuse indicate that Valium, the drug most often prescribed by doctors to treat anziety, has become the first choice of drug abusers (excluding alcohol). Since the danger of addiction to Valium is as yet unknown, this fact might escape the attention of or be of very little concern to health professionals or public officials involved in making drug policy. However, what is noteworthy is the increasing evidence that the people who are abusing Valium are often middle-class women who quite freely acknowledge their need for and their use of tranquilizers to help them through minor crises.

It is true that gaps in knowledge about women and drug dependency reflect, to some degree, the lag and the general lack of knowledge that existed in the past about alcohol and drugs. But the rapid growth of information in the past decade has not been matched by specific attention to women. There has not been

exploration of the varieties of situations which cause women to drink heavily or abuse drugs, the ways in which their habits are influenced by their restricted social roles, by limited economic opportunity, by the low self-esteem which they may experience because they are considered as second-rate human beings, and by the difficulties they may experience in developing competence in skills valued by society.

B. Youth

The problem of alcohol abuse, alcoholism, and the combined use of alcohol and other drugs among pre-teenagers and teenagers has grown to alarming proportions in New York City as it has throughout the country.

Dr. Morris Chafetz, Director of the National Institute on Alcohol Abuse, estimated recently that by conservative measures there are 450,000 preteenagers and teenagers (of 30 million between 12 & 21) with serious alcohol abuse problems. There are currently 25 Alcoholics Anonymous meetings throughout the country which are exclusively for pre-teenagers. The sale of pop wine - fruit flavored - which is used extensively by drinkers in this age group increased from 3 million bottles in 1968 to 33 million bottles in 1971. Federal Bureau of Investigation statistics reveal an increase in juvenile arrest for drunkenness of 200% from 1970-1972. Alcohol is the newest hard drug.

Teenage drinking appears to be most adequately understood as a social act, as a mechanism of identification, by which many teenagers attempt to relate themselves, however prematurely, to the adult world. This is indicated because

a segment of the cultural tradition to which the teenager is likely to be exposed has defined drinking in this way. Heavy drinking male adolescents consider themselves to be significantly more masculine than their peers; however, no similar sexual identity appears to exist among the girl heavy drinkers.

Fortunately, many young people are not in the bind of the struggle between the sexes. Groups of male and female youth focus on helping youth develop their own abilities to recognize their feelings and control their behaviors. They learn to make wise decisions choosing from a variety of options in regard to sex, drugs, careers, friendships, and drinking patterns. These approaches are particularly helpful to adolescents learning to deal with the symptoms which drug use means as they try to develop into adulthood. But can the HMO, with its medical orientation, broaden its services to include socio-psychological counseling groups as an affective preventive health service? If the limitations of third party reimbursement determine the program, HMOs may fail to serve these family members.

C. The Aging

Drug and alcohol abuse are also significant problems for the elderly individual, perhaps inadvertently when alcohol is used as a cure for insomnia, or as a means of escaping from loneliness, isolation, boredom, or other stresses of aging. Since the geriatric patient is rarely accepted for treatment by physicians who are reluctant to label an older person an alcoholic or addict or who assume a poor prognosis, little is known about the extent of the problem or the effectiveness of existing programs. However, there is evidence that the elderly person

with an alcoholism problem responds more readily to a therapeutic environment than the younger patient. As with youth, a more age specific approach is necessary, one which recognizes that elderly people can be alcoholics, that they can have active sexual lives, and that they too must be individualized at the same time that the particular demands of this critical period in life are recognized.

D. Children of Alcoholic Parents

Many professionals who work with alcoholism consider alcoholism a family problem in which the parental environment that includes alcoholism can be devastating to children.

Children who grow up in a family where one or both parents are alcoholics are exposed to a pattern of behavior that shows adults coping with stress by the use of alcohol and its acceptance as a necessary accompaniment of human pleasure and socialization. By the time children growing up in such an environment become aware of the social and physical decay of chronic alcoholism, the child may be reinforced and patterned toward excessive alcohol use. It is important for such children to be exposed to mature and esteemed models who demonstrate healthy attitudes and behavior toward alcohol use. Yet, membership in a family in which parents are alcoholics predisposes the development of lifestyles in which alcohol is the crutch or the salvation. Unless health maintenance means attention to those affected by the primary alcoholic patient, the potential victims are more likely to be damaged in the future in spite of the treatment of the disease.

## III. SOCIOCULTURAL ASPECTS OF ALCOHOLISM

More than many other diseases, alcoholism manifests itself not only in orga ic pathology, disfunction and physical illness, but also in social disability and emothinal disorder. We need only look at fellow employees imposed upon by the Monday morning absences to see the affects of alcoholism in the marketplace; a figure of four significant persons who are affected by the identified alcoholic patient conjures up images of angry spouses, frightened children, impatient and helpless parents. More dramatic, although less obvious, are those victims of highway mayhem and other violence. Yet, on the other hand, we know that more successful treatment programs have relied on group identification, support and presence, to supplement the medical detoxification so necessary in acute alcoholism and the psychological self understanding that is a part of the rehabilitative process. Sociocultural factors related to personality and behavior must be considered. Instead of a traditional psychaiatric approach focusing almost exclusively on individual psychopathology,with medical treatment, a more appropriate viewpoint to take is the sociopsychological orientation which considers all aspects of human life as deterrents or contributors to the development of human potential. Particularly in the development of alcoholism services, the primacy of community care must be accepted as not only appropriate but humane. In community alcoholism services, the emphasis is on planned links with other human services so essential to life - education, health, social welfare, the world of work - to encourage innovative measures that strengthen integrative forces, coping skills and social learning. This viewpoint seeks further to encourage the development of competence and power by persons who have been excluded by society, inhibited in selfactualization by virtue of factors of sex, race, economic status or label.

Societal group reactions and the attitudes toward social drinking, alcoholism and intoxication can be considered programmatic influences. To some degree, they determine whether or not insti tutions are even considered or created; they certainly determine who enters the care system and who the care takers are.

Alienation, anomie, and role diffusion increase in a rapidly changing society which reates uncertainty for women, which has no place for its minority youth, and is pervaded with fear, distrust and violence; unemployment mounts; widespread poverty exists side by side with affluence. For some, self-concern means success at the expense of others and at the sacrifice of family, leisure and self-esteem. The threat of automation is no longer 1984, but looms before the worker in a meaningless factory job, where even the satisfaction of an ever increasing gross salary does not mask the fact that he wages an uphill battle against debt, installment plans, and pressures to purchase more. Massive propaganda efforts are directed toward urging alcohol as the path toward closeness, intimacy, camaraderie, conviviality, and as a way of being part of the "in group". All of these make the likelihood of social sanctions against drinking and a disapproval of alcohol almost unthinkable.

Indeed, the pressures are quite the opposite. Society says, "Escape from stress by the pill or the bottle; find relief and love and ease in place of tension, isolation and disease." For youth, to identify with the behavior of adults is a

normal step in adolescence; this identification is hardly limited to those acts of adulthood which are positive, constructive and healthy. When the aimless lives of ghetto youghs seem all that lies before them, when the bravado of getting high and acting big join the culturally acceptable standards of weekend drinking, the use of alcohol to escape and solve inner emotional conflict reinforces what may be culturally acceptable mores.

It has been expressed that, if alcohol were to be introduced in this country today for the first time as a drug, even the Food and Drug Administration, not known for its ardent consumer interests, might consider it too toxic to market. Yet, its legality for adults and its availability at any age, coupled with the "hard sell" of the liquor industries, prove effective deterrents to limited programs of alcoholism abuse education.

Indeed, this points up the difficulties posed by societal pressures, which may be of more or less influence on the individual making choices, depending upon the expectations of the cultural group and the role that alcohol plays in these expectations.

The lack of attention to individual and group characteristics, and to the varied social situations in which women, young people, or the aging abuse alcohol is typical of a public policy that emphasizes symptomatic treatment while minimizing the social context, that pays little attention to prevention

and none to ameliorating conditions which facilitate drug dependency. In spite of the fact that we are already aware that alcoholism and other drug abuse know no barrier of race or economic class, the hard facts are that alcohol abuse is fostered and encouraged. After all alcoholism and drug abuse are not only diseases; they are billion dollar businesses. We decry the fact of the latter day interest of public policymakers in what was once a ghetto problem of hard drugs has now spread to the suburbs and the white communities. Yet, the patterns of heroin marketing, of the use and abuse of Valium barbiturates, are very different in the White and Black or Brown communities. Within the inner cities, our racial ghettos, the devastation of the heroin business is encouraged openly by police through their actions and inaction, by public disregard and apathy. Within the health care non-system, the "pushing" of the legal drugs is by the prescription writers, the physicians.

The criticism is valid that our health care is focussed too much on disease and treatment and too little on prevention and rehabilitation. Yet the problems of defining an appropriate preventive service are numerous; they cross the boundaries between health care and social service. Yet, even more than our traditional entrepreneurial fee-for-service system, organized health care settings are established to promote a higher level of health; this implies health, education and preventive efforts.

Those experienced in alcoholism prevention feel that dissemination of the warning signs for alcoholics must avoid scare tactics as well as moral posturing. Prevention programs are, by definition, focused on non-problems. Therefore, they must present alternatives rather than solutions. Early education in value clarification, development of decision-making skills, and exposure to alternative life styles and strategies for improving self-image should be stressed. On a larger scale, an attempt should be made to change the conditions which produce the alcoholic, through political and social action.

The effectiveness of some primary prevention programs may also be affected by society's acceptance of alcohol as a necessity for social interaction. Such customs as the "happy hour" encourage young people to pick up the habit as evidence of their maturity ... a way to cover up their lack of social graces.

The government and our capitalist values must also take responsibility for the perpetuation of certain drinking patterns, for the tendency to put profit-making ahead of health, mental health and the treatment of alcoholism. Like the tobacco industry, the manufacturers and distributors of alcoholic beverages have established powerful lobbying and interest groups to act on their behalf and the right to health is secondary. It is vital that the medical profession be educated concerning the abuse of drugs in all their forms, hard or soft, dry or wet. As responsible citizens, we must raise our voices against drug pushing, licit or illicit.

## V. HEALTH MAINTENANCE ORGANIZATIONS AND ALCOHOLISM SERVICES

Health Maintenance Organizations have an obligation, in the interest of preventive and comprehensive care, to turn their attention to special services for alcohol abusers and their families. In some ways HMOs enjoy a particular advantage to reach the hidden abusers, to attack problems in their incipient stage. With a staff alerted to the symptoms of alcoholism and through the medium of regular intensive work-ups, alcoholism cases which are often deliberately masked or obscured can be detected early and treated before severe illness develops. Furthermore, since HMOs are limited in their capacity to establish an effective program and to deal with this serious social problem. HMOs do not reach the most volnerable at-risk populations. Designed to cover employees or persons who can purchase health insurance, HMOs do not include the poor and those minority populations who are most likely to become alcoholics because of a lack of fulfillment or personal satisfactions.

Some proposals have been floated to draw Medicaid populations into a prepaid health care plan, but under present conditions without substantial increases in fee reimbursement or other governmental assistance, the costs of including this population have been deemed prohibitive. In New York City, a plan is being discussed for Health Insurance Plan (HIP) coverage for a small group of Medicaid patients. It is interesting to note that in the initial stages of negotiation, alcoholism services were specifically excluded because the costs of admitting such patients into the plan would be extraordinarily high. Clearly, an insurance

plan based on average costs of maintaining health for a customarily healthy group is not applicable to poor and minority populations who have excessive morbidity rates and greater need for services.

The economies derived from preventive, comprehensive care, which is the keystone of HMOs, are not realized, however, within the narrow perimeter of an HMO itself, but throughout the health care system. The costs to the state, federal and local governments, as well as to voluntary agencies and private practitioners must be measured against the cost of comprehensive care provided by an HMO. So far, neither the government nor HMOs have proceeded with deliberate speed or determination along these lines. HMOs continue to concentrate on serving a selected population, containing costs by limiting services to a less unhealthy and less needy population. The government has not as yet taken a positive and effective stance on encouraging the proliferation of prepaid plans for the purpose of preventing serious illness and improving the quality of health care for all its people.

HMOs originated as associations of physicians; they have been fashioned from a medical model and provide few ancillary services. Some HMOs have no social workers; most HMOs have very modest psychiatric and counseling services and few para-professionals on the staff. Fundamental to a successful alcoholism program is the battery of non-medical services: counseling, social rehabilitative services and psychiatric help. In order to establish a satisfactory alcoholism

treatment program, HMOs would have to develop new organizational models or on a contractual basis would refer patients to an existing center.

Dealing with the alcohol abuser is only one part of the severe social problem confronting us. The spread of the disease, its persistence and virulence can only be checked through a vigorous and continuous prevention program. Educational and outreach services are beyond the financial capacity of HMOs as they are now constituted. But it is in this area that our efforts must be concentrated in order to heighten community awareness of the problem, to encourage alcohol abusers and their families to seek treatment, and to create a climate hospitable to provision of services. While HMOs could be enlisted to collaborate in a nationwide campaign to sensitize communities to the gravity of alcoholism, to educate, inform and persuade, the responsibility for so vast and far-reaching a project must be primarily with the government.

The cooperation of citizens, of neighborhood action groups and consumer organizations is vital. For it is only with their earnest participation that an educational campaign can have impact. The professionals, the practitioners and experts may embark on the most ambitious and well-conceived project, but those who are to hear the message will feel they are being sermonized and hectored. They will not listen; they will not heed the most cogent, well-intentioned arguments. On the other hand, if their cooperation is sincerely solicited, if citizen participation is a meaningful component of the program design and execution, the chance for a productive educational effort are greatly enhanced. Consumer involvement may be increased within the framework of HMOs, and for many reasons apart from the establishment of alcoholism services, it might well

be considered as an agenda item. But the scale in which it is suggested for massive outreach and educational programs to combat alcoholism would require the resources and financial underwriting of governmental authorities.

Within the current structure, however, and despite the limitations noted, HMOs can expand their scope and provide the much needed services to persons already enrolled and to their families. With changes in the fee system, coverage could be extended to the more susceptible and volnerable populations.

A variety of helpers and of services is needed. To move from the extreme of non-understanding and rejecting physicians to rely solely upon staff recruited from the ranks of recovered alcoholics as counselors, might be to repeat the earlier error of rigidity. Instead, the flexibility of varied staff patterns utilizing both professionals and paraprofessionals along with components such as AA and other self-help efforts built in, means not only that there can be an understanding of the culture from which the patient or client comes, but that there can also be different styles of engagement.

This means that staff education is essential both to develop awareness of alcoholism symptoms so that treatment can be recommended and to train practitioners on all levels of effective techniques. It also means recruitment of staff which is especially equipped to deal with alcoholics and experienced with different approaches. Linkages must be established with social agencies, rehabilitation centers, halfway houses and other facilities providing psychosocial and educational services.

What is needed further, is a change in attitude by the medical profession to recognize the crucial importance and influence of socio-economic factors on health, and from this recognition must come the responsibility to incorporate in the health care system treatment modalities which address those social ills producing the manifest physical symptoms. This is without doubt a primary obligation of a health maintenance organization which purports to preserve and enhance the health of its constituents.